COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

TRANSITION AGE YOUTH (TAY) (16-25)
FULL SERVICE PARTNERSHIP
REFERRAL FORM

REFERRAL INFORMATION

***Insufficient details may delay referral process**

DATE: _____ **DMH IBHIS#:** _____

SSN: _____

LAST NAME: _____ **FIRST NAME:** _____ **PREFERRED LANGUAGE:** _____

DOB: _____ **AGE:** _____ **RACE/ ETHNICITY** _____ **GENDER:** ☐ **M** ☐ **F** ☐ **UNKNOWN**

CONTACT ADDRESS: _____ **CITY:** _____ **ZIP CODE:** _____

PHONE: _____ **CURRENT LIVING SITUATION:** _____

INSURANCE: ☐ **MEDI-CAL** ☐ **HEALTHY FAMILIES** ☐ **HEALTHY KIDS** ☐ **PRIVATE** ☐ **NONE**

BENEFITS: ☐ **GR RECIPIENT** ☐ **V.A.** ☐ **SSI** ☐ **SSDI** ☐ **OTHER INCOME**

☐ **CLIENT SERVED IN THE MILITARY**

PRIMARY CONTACT: _____ **RELATIONSHIP:** _____

PREFERRED LANGUAGE: _____ **PHONE:** (____) _____

CONSERVATOR ? ☐ **YES** ☐ **NO** **NAME:** _____ **PHONE:** (____) _____

REFERRAL SOURCE

Agency: _____ Contact Person: _____

Phone: _____ Fax: _____ E-mail: _____

Is Individual currently receiving mental health services from your agency? ☐ YES ☐ NO

Other Agency Involvement: ☐ DCFS ☐ Probation ☐ DMH ☐ Regional Center ☐ Parole: ☐ Division of Adult Parole Organization/DAPO*
☐ Post-Release Community Supervision/PRCS**

***Eligible for FSP services, but MHSA funds may <u>not</u> be used to serve them. Must serve those who are Medi-Cal beneficiaries if they meet Specialty Mental Health Services (SMHS) criteria regardless of whether the beneficiary is currently receiving mental health services through the state parole system.**
****Not eligible for FSP services. Refer to AB 109 program by calling (213) 738-2877.**

LEVEL OF SERVICE

Individual's Name: _____

DMH IBHIS#: _____

Check ONE ONLY:

- ☐ Unserved (Not receiving mental health services)
  - ☐ History of mental health services, but none currently* ☐ No prior mental health services
- ☐ Underserved (Receiving some MH services, though insufficient to achieve desired outcomes)*
  - ☐ Recovery, Resilience & Reintegration Services ☐ PEI ☐ Other: _____
- ☐ Inappropriately served (receiving some MH services, though inappropriate to achieve desired outcomes because of cultural, ethnic, linguistic, physical, or other needs specific to the client)*

*If client has received community-based mental health services within the last 6 months, (1) identify the program(s); (2) indicate the type and frequency of services; and (3) explain why the services are insufficient/inappropriate to achieve desired outcomes:

_____

_____

_____

_____

_____

DIAGNOSTIC CONSIDERATIONS

Primary **ICD-10 Diagnosis**: _____

Check All that Apply to Individual:

- ☐ Aggressive Ideation
- ☐ Aggressive Acts (by history or current)
- ☐ Aggressive Threats (by history or current)
- ☐ Fire Setting Ideation or Acts
- ☐ Inappropriate Sexual Ideation
- ☐ Inappropriate Sexual Acts
- ☐ Psychiatrica Hospitalizations (Indicate dates below)
- ☐ Suicidal Ideation/Attempts
- ☐ Symptoms of Psychosis
- ☐ Tarasoff Notifications (past or current)
- ☐ Other _____

Provide Detail for Any Checked Items: _____

_____

_____

_____

All DMH entities (directly-operated and contracted) must submit the Referral/Authorization Form via the Service Request Tracking System (SRTS). For Non-DMH entities, please fax the completed Referral/Authorization Form to the Impact Unit for your Servica Area:

SA 1: Salem Redding	(661) 537-2937	SA 4: Hannah Lee	(213) 680-3225	SA 7: Cheryl Lopez	(213) 384-0729
SA 2: Nancy Garcia	(818) 347-8738	SA 5: Jacqueline Finch	(310) 313-0813	SA 8: Mary Marroquin	(562) 290-1230
SA 3: Socorro Ramos	(626) 331-0121	SA 6: Gerri Washington	(562) 929-4932		

FOCAL POPULATION

Individual's Name: _____

DMH IBHIS#: _____

Check either A. or B.

If the client meets the focal population for section A. and/or B., the referral requires authorization.

A. ☐ FOCAL POPULATION REASON(S)
B. ☐ AT-RISK REASON(S)

TAY must have a Serious Emotional Distubance (SED)* and/or Severe and Persistent Mental Illness (SPMI)**

A. CHECK APPROPRIATE FOCAL POPULATION REASON(S) FOR REFERRAL:

1. ☐ Youth aging out of:
   ☐ Child Mental Health System ☐ Child Welfare System ☐ Juvenile Justice System
2. ☐ Youth leaving Long-term Institutional Care
   ☐ Level 12-14 Group Homes ☐ Community Treatment Facility (CTF) ☐ Jail
   ☐ Institution of Mental Disease (IMD) ☐ State Hospital ☐ Probation Camps
   Estimated Discharge Date: _____
3. ☐ Youth experiencing their first psychotic break
4. ☐ Co-Occurring Substance Abuse Disorder **in addition** to meeting at least one (checked) TAY focal population criteria identified above.
5. ☐ Homeless (Indicate current living situation): _____
   ☐ Chronically Homeless (HUD Standards)***

Provide Detail for Any Checked Items:

_____

_____

_____

B. CHECK APPROPRIATE AT-RISK REASON(S) FOR REFERRAL:

1. ☐ At risk of homelessness: unstable, sporadic housing/multiple placements
2. ☐ Currently a victim of commercial sexual exploitation
3. ☐ Youth with a history of commercial sexual exploitation

* (SED) "Seriously emotionally disturbed" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 or Title 1 of the Government Code. [California Welfare and Institutions Code Section 5600.3]

** (**SPMI)** For TAY ages 16-25 may include significant functional impairment in one or more major areas of functioning (e.g., interpersonal relations, emotional, vocational, educational, or self-care) for at least 6 months due to a major mental illness. The individual's functioning is clearly below that which had been achieved before the onset of symptoms. If the disturbance begins in childhood or adolescence, however, there may be a failure to achieve the level of functioning that would have been expected for the individual rather than deterioration in functioning.

*** **Chronic Homeless HUD**: A person sleeping in a place not meant for human habitation or emergency shelter with a disabling condition who has been continuously homeless for a year or more and/or an individual who has had 4 episodes of homelessness in the past three years.